Increase in newly diagnosed **HIV/AIDS** continued

only eight cases were reported among individuals in the same age group in all of 2007. Many of the new reports are among residents in southeastern Idaho, where Southeastern District Health Department recently announced an alarming increase in newly identified cases over the past several months.

Initial interviews with some of the newly diagnosed cases suggest there may be a perception that the risk of HIV infection is low. This may be due in part to decreased coverage of HIV/ AIDS in popular media in recent years.

The 2008 reports are among people engaging in several known and more recently identified risk behaviors including:

- Having unprotected sex with multiple sexual partners, including finding anonymous partners through Internet sites;
- Men having unprotected sex with other men (MSM); and
- Injection drug use (IDU).

Among reports of males, two thirds were MSM. Most reports among women are reported heterosexual exposure with a high-risk partner

Table: Reported HIV/AIDS diagnoses by sex and mode of exposure—Idaho, 1/1/2008–10/31/2008			
Mode of exposure	male	female	total
MSM	21	N/A	21
IDU	1	1	2
MSM/IDU	1	N/A	1
Heterosexual exposure	4	8	12
Risk not identified	5	0	5
Total	32	9	41

N/A = not applicable

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The Idaho Department of Health and Welfare (IDHW) and Idaho local public health districts are recommending physicians screen patients

for HIV in accordance with the most recent Centers for Disease Control and Prevention (CDC) recommendations. For all healthcare settings, routine screening for HIV is recommended at least once in patients aged 13-64 years. Assessment of risk of HIV infection should be incorporated into routine primary care for all sexually active persons. Healthcare providers should test all persons likely to be at high risk for HIV at least annually.

The public has been informed of the recent increase in HIV/AIDS diagnoses via local and statewide press releases that resulted in both television and print coverage, and advised to seek testing by their private health care provider or local public healt districts, if at risk.

The CDC estimates that 21% of HIV-infected persons are not aware of their HIV-positive status. Infected persons who have not been diagnosed are not able to receive potentially lifesaving medication, and may unknowingly spread the virus.

> .vog.odsbi.iqs.www are archived online at Current and past issues of this bulletin

hdq.0150/01 feqebi/səluri/səluri mbe/vog.odebi.mbe//:qttd Idaho Reportable Diseases may be found at An electronic version of the Rules and Regulations Governing

> Reporting Line 1.800.632.8000 **EMERGENCY 24-Hour**

Disease Reporting Line 1.800.632.5927 ROUTINE 24-Hour

> Boise, ID 83720-0036 P.O. Box 83720 Division of Health

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Office of Epidemiology and **Food Protection**

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more inside

- **▶** Data Snapshot: **Immunizations**
- ► Smoking and **Respiratory Disease in** Idaho

An Alternative to TB Skin Testing is Now Available!

The Idaho public health laboratory is now offering the QuantiFERON®-TB Gold In-Tube test (QFT-GIT), a blood test that can aid in diagnosing Mycobacterium tuberculosis (TB) infection, including latent infection and active disease. Results are based on the amount of interferon-gamma that is released after a 16 to 24 hour incubation of the blood with specific antigens.

Advantages of the QFT-GIT test over the tuberculin skin testing include:

- Requires only one patient visit to draw a blood sample; no subsequent "reading" of the test needs to be done.
- Results can be available within 24 hours.
- Results are not affected by prior BCG (bacille Calmette-Guérin) vaccination.

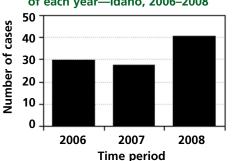
Disadvantages and limitations include:

- There are limited data on the use of QFT-GIT in children younger than 17 years of age, among persons recently exposed to M. tuberculosis, and in immunocompromised persons (e.g., impaired immune function caused by HIV infection or acquired immunodeficiency syndrome [AIDS], current treatment with immunosuppressive drugs, selected hematological disorders, specific malignancies, diabetes, silicosis, and chronic renal failure).
- Errors in collecting or transporting blood specimens or in running and interpreting the assay can decrease the accuracy of QFT-GIT.
- Unlike the skin test, there are limited data on the use of QFT-GIT to determine who is at risk for developing active TB (e.g., it is not known what the likelihood of someone with a newly positive QFT-GIT test is for developing active TB within a year, whereas the general risk for someone with a newly positive skin test is known).

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Increase in Newly Diagnosed HIV/AIDS **Reports Prompts Health Alerts**

Figure: Number of newly reported HIV/AIDS cases during the first 10 months of each year—Idaho, 2006-2008



Idaho is experiencing an increase

in reported human immunodeficiency virus (HIV) infections in 2008.

During the first 10 months in 2008, 41 Idaho residents have been reported with newly diagnosed HIV or AIDS, with additional reports under investigation (preliminary data). This number of reports is a 46% increase over the 28 reports from the same time period last year, (Figure) and includes 14 cases among individuals aged 24 years or younger. By comparison,

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An alternative to TB skin testing continued

As with the skin test, clinical evaluation and additional tests (such as a chest radiograph, sputum smear, and culture) are still needed to confirm the diagnosis of active TB. QFT-GIT can be used in all settings in which the skin test is currently used, including contact investigations, evaluation of recent immigrants who have had BCG vaccination, and TB screening of health care workers and

others undergoing serial evaluation for *M. tuberculosis*. For providers, using QFT-GIT may decrease confusion when persons known to have been vaccinated with BCG are to be tested. Please contact Dr. Christine Hahn at (208) 334-5939 or Vivian Lockary, state public health laboratory microbiologist, at (208) 334-2235, if you have questions about using QFT-GIT.

Data Snapshot: Immunizations

Idaho's childhood immunization rates for children ages 19–35 months are the third lowest in the country. While there are multiple shots that are evaluated for completeness, there are a few that have traditionally had lower completeness rates in Idaho than others. The diphtheria, tetanus, and pertussis (DTaP) vaccine is one of these.

For complete protection from disease, a child needs 4 doses of DTaP by 18 months of age. In Idaho, most children (89.7%) receive 3 doses of DTaP; however 17% of these fail to return for the fourth dose (Figure). By comparison, 95% of all children nationwide receive 3 doses of DTaP

and 81.1% receive the fourth dose. In order to prevent outbreaks of some diseases including measles, high levels of immunity must be present. Pertussis outbreaks occur every year in Idaho. With only 75% of young children appropriately vaccinated, it leaves many children at serious risk of this disease as well.

To help increase Idaho immunization rates, providers should ensure the fourth dose of DTaP is administered by checking immunization status at all well- and sick-child visits. If a child is unable to be vaccinated during a visit, schedule an immunization visit to get them back on schedule. Every clinic should have a system to

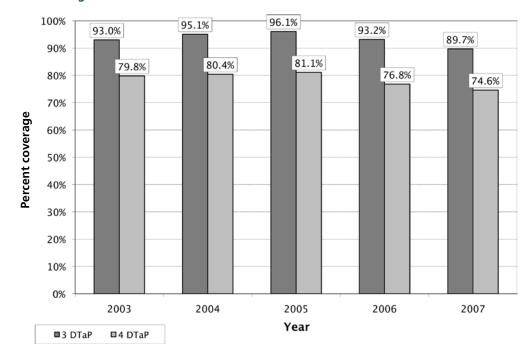
identify children that are either due for, or are behind on, their immunizations. Idaho's Immunization Registry Information System (IRIS) can help providers keep track of what shots a child needs and identify children that are behind.

For more information see https://iris.idaho.gov or contact the Idaho Immunization Program at (208) 334-5931.

REFERENCES

1 Centers for Disease Control and Prevention. Immunization Coverage in the U.S. http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis. Updated October 9, 2008 Accessed November 24, 2008.





Smoking and Respiratory Disease in Idaho

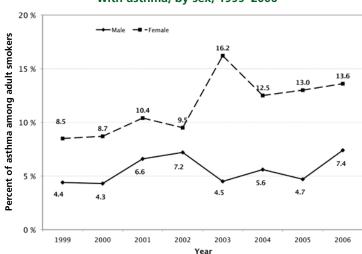
Diseases caused by smoking cigarettes result in more than 443,000 deaths in the US annually. In addition to being directly responsible for the majority of lung cancer cases, smoking can also exacerbate other chronic and infectious respiratory ailments. Cigarette smoking has, for instance, been found to be a strong independent risk factor for invasive pneumococcal disease among immunocompetent, nonelderly adults. New immunization guidelines, summarized below, will soon be available to help providers better manage this increased risk of disease among patients who smoke.

In 2007, 286,000 Idaho adults (19% of Idahoans aged 18 and older) and 17,500 high school students (20% of Idahoans enrolled in grades 9–12) smoked cigarettes on one or more of the previous 30 days.³ Smoking rates are typically higher among young adults, as well as adults with lower educational levels or annual household incomes. Several other demographic groups in Idaho have substantially higher smoking rates. These groups (and the proportion who smoke) include: Native American adults (37%) and teens (28%); Hispanic adults (24%); African American adults (48%), Medicaid-eligible adults (39%); and lesbian, gay, bisexual, or transgender (LGBT) adults (35%).⁴

Research shows that smokers with asthma are likely to suffer increased symptom severity and mortality related to asthma attacks.^{5,6} Despite the evidence of increased adverse affects, however, smoking rates among Idaho adults with asthma are equivalent to those of the general population. Additionally, female adult smokers have a substantially higher prevalence of asthma than male smokers (Figure). Both female and male smokers with asthma require vigilant medical management of their disease along with emphasis on tobacco cessation.

In October, the Advisory Committee on Immunization Practices (ACIP) recommended, for the first time, a vaccination to be given based solely on smoking status. Pneumococcal vaccine (PNEUMOVAX® 23) is now rec-

Figure: Percent of Idaho adult cigarette smokers with asthma, by sex, 1999–2006



ommended for all adult smokers due to their high risk of pneumococcal disease (http://www.cdc.gov/vaccines/recs/provisional/default.htm). This new recommendation has not yet been formally adopted by the Centers for Disease Control and Prevention (CDC), but ACIP recommendations are usually adopted quickly by the agency. Once adopted, this recommendation will impact a significant number of Idahoans. In 2007, 78% of Idaho adult smokers (or roughly 200,000 individuals) stated they had never received a pneumonia vaccine.⁷

In addition to the health burden that smoking inflicts on the people of Idaho, it is estimated that annual smokingrelated health care costs are \$292 million, and productivity losses are \$332 million in Idaho alone. According to the US Public Health Service's updated clinical guidelines for tobacco treatment, "Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco."8 Brief online guidelines are available for clinician use to assist patients in quitting (http://www. ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm). There are some limited resources for smoking cessation treatment for lower-income smokers in Idaho. A voluntary Medicaid program, Preventive Health Assistance (PHA), provides beneficiaries with up to \$200 in vouchers for counseling, medication, or nicotine replacement products upon completion of a treatment plan. The PHA brochure may be found at http://healthandwelfare.idaho.gov/site/4161/default.aspx. Click "PHA Brochure" under the "Participant Information" heading on the far right-hand side. Additional resources include a free telephone counseling service (Idaho Quitline at 1-800-QUIT-NOW) and a free online tobacco cessation support center (http://idaho.quitnet.com).

REFERENCES

- Adhikari B, Kahende J, Malarcher A, Pechacek T, Tong V. Smokingattributable mortality, years of potential life lost, and productivity losses - United States, 2000-2004. MMWR. 2008, 57(45);1226-1228.
- 2 Nuorti JP, Butler JC, Farley MM, Harrison LH, McGeer A, Kolczak MS, Breiman RF. Cigarette smoking and invasive pneumococcal disease. *New England Journal of Medicine*. 2000, 342:681-689.
- 3 Idaho Department of Health and Welfare. Idaho Youth Risk Behavioral Survey (YRBS) 2007. Boise, ID: Idaho Department of Health and Welfare, Bureau of Community and Environmental Health, Tobacco Prevention and Control Program, 2008.
- 4 Idaho Tobacco Prevention and Control Program, Programmatic surveillance data.
- 5 Eisner MD, Yelin EH, Trupin L, Blanc PD. Asthma and smoking status in a population-based study of California adults. *Public Health Reports*, 2001, 116:148-157
- 6 Althius MD, Sexton M, Brybylski D. Cigarette smoking and asthma symptom severity among adult asthmatics. *The Journal of Asthma*, 1999. 36:257-264.
- 7 Idaho Department of Health and Welfare. Idaho Behavioral Risk Factors: Results from the 2007 Behavioral Risk Factor Surveillance System. Boise, ID: Idaho Department of Health and Welfare, Bureau of Vital Records and Health Statistics, 2008.
- 8 U.S. Department of Health and Human Services, Public Health Service. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence. Clinical practice guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2008 May. 257 p. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.28163



